



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4812 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ROGELIO RODRIGUEZ, DC  
4602 WASHINGTON AVE, STE A  
HOUSTON, TX 77007

#### **Respondent Name**

ZURICH AMERICAN INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-09-6963-01

#### **MFDR Date Received**

March 16, 2009

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary from the Table of Disputed Services:** "pre-authorization obtained. Preauthorization not necessary for the first visits after surgery per TDI-DWC rules, subchapter G 134.600 (p)(5)(c)(ii)."

**Amount in Dispute:** \$381.71

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary from the Table of Disputed Services:** "Did not provide required modifier per Medicare guidelines."

**Response Submitted by:** Zurich American Ins. Co., 300 S. State St., Syracuse NY

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2008 to July 15, 2008	97110-GP, 97140-GP, 97032-GP, 97035-GP	\$381.71	\$350.82

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization of specific treatments and services.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.

5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 23, 2008

- 4-The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding. Billing and reimbursement methodologies.

Explanation of benefits dated July 1, 2008

- 4- The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding. Billing and reimbursement methodologies.

Explanation of benefits dated July 8, 2008

- 4- The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding. Billing and reimbursement methodologies.

Explanation of benefits dated August 21, 2008

- 4- The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding. Billing and reimbursement methodologies.

Explanation of benefits dated November 24, 2008

- 29-The time limit for filing has expired. Per Texas Labor Code 408.027 bills must be sent to the carrier on a timely basis, within 95 days from the dates of service

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## **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor timely submit disputed bills in accordance with Texas Labor Code §408.027(a) and 28 Texas Administrative Code §133.20?
3. Did the requestor apply the correct modifiers to the disputed services in accordance with Per 28 Texas Administrative Code §133.20(c)?
4. Did the disputed services require preauthorization in accordance with 28 Texas Administrative Code §134.600 and is requestor entitled to reimbursement?

## **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided.” No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” 28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.” Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute. Review of the requestor's EOB's support that the respondent received the disputed bills within 95 days from the date the services were rendered in accordance with 28 Texas Administrative Code §133.20.
3. Per 28 Texas Administrative Code §133.20(c) states, “A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills. Under the title Medicare Part B- Modifiers/Physical Occupational Therapy, it states that a GP modifier is required for services delivered under an outpatient physical therapy plan of care. Review of the requestor's bills submitted finds that the requestor, upon reconsideration, included the GP modifier for the disputed physical therapy CPT codes. Therefore, the disputed services will be reviewed in accordance with 28 Texas Administrative Code §134.203 and Per 28 Texas Administrative Code §134.600.
4. Per 28 Texas Administrative Code §134.600 (p)(5)(A)(ii) & (C)(ii) states, (p)“Non-emergency health care

requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (ii) Therapeutic procedures, excluding work hardening and work conditioning; and (C)(ii) states, except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (ii) a surgical intervention previously preauthorized by the carrier” Review of the requestor’s documentation submitted finds two preauthorization letters dated April 4, 2008 and June 16, 2008 to support preauthorization was obtained for CPT code 97110 for disputed dates of service April 15, 2008 and July 15, 2008. Further review of documentation finds a copy of a Post Operative Evaluation which notates that surgery to the right ankle was performed on May 30, 2008. Therefore, reimbursement is recommended for CPT codes 97110, 97140, 97032, and 97035 as follows per 28 Texas Administrative Code §134.600 and 28 Texas Administrative Code §134.203:

CPT code 97110 (2 DOS): 52.83 WC CF/38.087 Medicare CF x 27.53 Participating amount x 7 units = \$267.31. The requestor is seeking \$237.58. This amount is recommended.

CPT code 97140 (2 DOS): 52.83 WC CF/38.087 Medicare CF x 25.50 Participating amount x 2 units = \$70.74. The requestor is seeking \$63.78. This amount is recommended.

CPT code 97140 for DOS July 15, 2008: No documentation was found to support that preauthorization was obtained for this CPT code prior to rendering service. No reimbursement is recommended.

CPT code 97032 (2 DOS): 52.83 WC CF/38.087 Medicare CF x 25.50 Participating amount x 2 units = \$70.74. The requestor is seeking \$34.90. This amount is recommended.

CPT code 97035 (1 DOS): 52.83 WC CF/38.087 Medicare CF x 11.28 Participating amount x 1 unit = \$15.65. The requestor is seeking \$14.56. This amount is recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$350.82.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$350.82 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

08/03/2012  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**